III. D. Reconstruction and Rehabilitation of Basic Health Centres and Sub-centres

According to preliminary estimates, some 70 basic health centres and 76 sub-centres may have to be rehabilitated. It is, however, certain that the numbers, country-wide, will be much larger and may run into hundreds. A reasonable number of mobile clinics will have to be provided also to provide outreach facilities and to strengthen the primary health care chain. In addition to provisions based on WHO lists of essential drugs for various categories of health units, some other equipment like beds, laboratory facilities, minor emergency facilities, etc., will have to be catered for. For this purpose a total sum of US$ 20 million has been estimated.

III. E. Logistics for Health Services

For the massive supplies, storage, distribution and maintenance tasks, major logistics support will be necessary. Apart from vehicles and transport, provision will be required for spare parts, back-up and repair facilities to avoid logistic breakdowns. For this purpose, a total sum of US$ 15 million has been provided in the budget estimates.

III. F. 1. Immunization

The programme will be targeted to the population at risk (mothers and children) and directed at control of the six diseases preventable by immunization, i.e., diptheria, whooping cough, poliomyelitis, tetanus, tuberculosis and measles.

Based on a population estimate of 10 million in Afghanistan and 3 million "returnees", the target population for immunization can be estimated as follows:

- Children 0 - 11 months	-	446 000
- Children 12 - 23 months	-	443 000
- Children 24 - 35 months	-	442 000
Total Children	-	1 331 000

(Calculated on the available figures of birth rate and infant/child mortality rates)

- Women aged 15 to 44 years	-	2 260 000
- Pregnant Women	-	520 000

Costs

Assuming cost of immunization per child to be $10, total expenditure of immunization of children would be $10 331,000.

Assuming cost of immunization per woman against neonatal tetanus to be $8, budget estimate for this purpose, if all women of child bearing age are to be protected, would be $ 18 080 000. In case, however, immunization is to cover

only pregnant women, a total of $4 160 000 will be required.

These costs include all aspects of an immunization programme for the population at risk. It is assumed that salaries and allowances for staff will be borne by the national authorities in which case a proportionate reduction in estimates can be made. Normally this element is reckoned to be 50% of the total costs. In the case of Afghanistan this may not be possible, particularly for immunization campaigns in areas to which the refugees and the internally displaced return and where the national authorities may not be in a position to provide requisite personnel. In this case, proportionate provisions for this purpose will have to be made. In any case, provision for field allowances for staff will have to be retained in these estimates.

Out of the other 50% of the total costs, following breakdown of expenditures is taken into account:

- Provision of vaccine	- 14%
- Vaccine supplies	- 2%
- Cold chain equipment	- 1%
- Vehicles	- 3%
- Training of personnel	- 5%
- Capital costs (Storage, warehouse, refrigerators, etc.)	- 10%
- Other operational costs	- 15%

The following vaccines will be required:

- BCG (initial and booster at school entry), DPT, Measles, Poliomyelitis, DT (for booster dose at school entry), Tetanus (for women).

Storage and distribution facilities, required at Central, Provincial, and District, Rural/Basic Health Centres are included in the capital costs.

Cold chain equipment includes Refrigerators/Freezers (Kerosene/Gas operated), Cold boxes, Icepacks, Vaccine Carriers, Thermometers, Monitoring Equipment (Alarm Systems, etc.) and refrigerated vans for transportation and distribution of vaccines. The cost of Vehicles including a sufficient number of motor cycles, for outreach collection and immunization, for collection and distribution of supplies and transportation of personnel are included under the heading "Logistics for Health Services".

Immunization equipment at health centres/basic health units will include plastic syringes (0.1 - 1.0 ml), mixing syringes (5.0 ml), forceps, heater (kerosene), steam sterilizer, needles (assorted), time clock, cotton wool, soap, skin-cleaning material, etc.

In the absence of latest reliable information regarding conditions

generally prevalent in Afghanistan, it can be assumed that, except for Kabul and its immediate surroundings, a countrywide immunization campaign will be required. Situation amongst the returning refugees may be comparatively satisfactory in view of a reasonable coverage through the Afghan Refugee Health Programmes. However, the overall programme should be on the basis of combination of both a short duration campaign and a programme to strengthen the immunization services for the longer term. It is also considered more practicable for the present, considering the budgetary and operational constraints, to restrict immunization of women, to pregnant women only, enlarging the scope to cover all women of child-bearing age at a later date.

Estimated costs shown above (approximately US$ 14.50 million) are a part of the total of US$ 20.0 million provided under this heading in the total estimates. The balance would be utilised on expansion/strengthening of the immunization programme.

SUMMARY COSTS FOR IMMUNIZATION PROGRAMME

Estimated population for immunization

- Children - 1 331 000
- Women - 520 000

Costs

Children at $10 per child		$ 10 331 000
Pregnant Women at $8 per woman		4 160 000
	Total	14 491 000

Breakdown of Costs

- Personnel - 50%
- Vaccines - 14%
- Vaccine Supplies - 2%
- Cold Chain Equipment - 1%
- Vehicles - 3%
- Training - 5%
- Capital Costs - 10%
- Other Operational costs - 15%

III. F.2. Malaria Control

Malaria has always been a major health problem in Afghanistan. A strong malaria control programme has been operational for a number of years and had, prior to 1979, managed to significantly bring down the incidence. The situation in the country prevalent since then, however, has reversed the position resulting in malaria incidence rising to an epidemic level. According to figures available, from as low as 36 195 cases detected in 1979, the number has risen to 227 851 in 1985 and further doubled to 422 415 between 1985-86. This is despite the fact that almost a third of the country's population are refugees in Pakistan and Iran where, too, malaria incidence has been a major health problem among them. The situation among the latter, however, is less alarming and the Refugee Health Programme, in fact, has substantially reduced the incidence.

Most of the cases in Afghanistan were of Plasmodium Vivax type susceptible to chemotherapeutic treatment and control. An additional problem has, however, been introduced by the rise in cases of Plasmodium Falciparum, resistant to commonly used chemotherapeutic drugs (Chloroquine). From an incidence of 143 in 1985, the P. Falciparum cases had risen to 509 in 1986, indicating a dangerous introduction of drug-resistant strains. Epidemics of malaria have been reported from the eastern and northeastern regions bordering Pakistan and in areas to which refugees, as well as the majority of the internally displaced, are expected to return. The implications are obvious for the returnees, despite a lowering of incidence in their present locations. A similar situation would prevail on the Iranian side. A well-planned, organized and effectively managed country-wide Malaria Control Programme must, therefore, constitute a major thrust and component of the health sector programme during repatriation, recovery and rehabilitation phases. This programme, through its vector control operations, will simultaneously assist in Leishmaniasis control.

The programme will aim to:

- reduce malaria and leishmaniasis morbidity;
- prevent mortality from malaria particularly among infants;
- concentrate efforts in areas with epidemological incidence;
- strengthen quality and quantity of malaria control programme personnel with recruitment, intensive training and retraining;
- prevent spread of malaria in areas of socio-economic importance.

Activities will include:

- diagnosis and treatment, including case-detection;
- mass drug distribution for prophylactic treatment of population at risk, returnees and locals alike;

- chemoprophylaxis of groups at special risk like children, mothers and pregnant women;
- vector control by residual spraying operations;
- antilarval operations in identified areas.

Financial implications and budgetary estimates, given below, have been worked out taking into consideration ten million local population and three million returnees for a period of 18 months to two years (two cycles). They are further based on the estimation that nearly two million cases of malaria (mainly P. Vivax) would have occurred in 1987 in Afghanistan and a million cases would be expected to occur among the refugees. The latter is not an unrealistic figure considering that refugees will be returning to areas where no control measures have been operational for a long period and where epidemics of malaria have been recurrent. Chemoprophylaxis will, therefore, have to be generalised.

Resources Required	Cost in $
1. Personnel (5) Malariologist, Entomologist and Technical Officers.	780 000
2. Supplies and Equipment	
2.1. Antimalarial drugs	
- Choloroquine (150 mgm base) (3 million cases/year x 2 + 10% x 10 tablets x $10) / 1000 (1 tin)	660 000
- Primaquine (15 mgm base) (2 million cases/year x 2 + 10% x 15 tablets x $6) / 1000 (1 tin)	396 000
- Sulfadoxine (500 mgm) Pyrimethamine (25 mgm) (For resistant cases) (5000 cases/year x 2 + 10% x 3 tablets x $100) / 1000 (1 tin)	3 300
Sub-total	$1 839 300

2.2. Insecticides and spraying equipment.

Estimates are based on the available information that in 1986, nearly 6 million people were residing in areas where malaria incidence was on the rise, reaching epidemic proportions. About 2 million were living in areas where malaria vectors remained susceptible to DDT and 4 million were in areas where malathion was the effective insecticide.

- DDT 75% (w.d.p.) 2 million people x $50m^2$ x 2.67g. x 2 rounds x $3 000	1 602 000
- Malathion 50% (w.d.p.) 4 million x $50m^2$ x 4.0 g x 4 rounds x $3 500	11 200 000
- Temephos (EC 50%) (for antilarval operations) 10 000 litres x $25	250 000
- Sprayers (Hudson x-pert 4 gallon) $\frac{6 \text{ million} \times 50 \text{ m}^2}{2000\text{m}^2 \times 40 \text{ working days}} = 3\ 750$ 3 750 + 20% reserve = 4 500 4 500 x $150 (including spare parts)	675 000
Sub-total	13 727 000

2.3. Laboratory Supplies and Equipment (microscopes, slides, reagents)
Out of 250 malaria posts established 10 years ago, only 100 are now stated to exist, 150 having been destroyed. These will have to be re-established and another 50 such posts established to cater for transitional camps/ locations for the returnees.

- 200 microscopes + 20% reserve = 240 240 x $1000	240 000
Equipment and supplies (Slides 1 500 000; 250 litres of Giemsa reagent in bottles of 100 ml each; 125 000 Buffer tablets - PH 7.2; 500 Slide boxes - WHO pattern)	135 000
Sub-total	375 000

3. Transport (for delivery of insecticides, spraying gangs and supervisory work in 8 malaria regions)		
- Pick up (8 for regions, 4 for returnees locations, 2 for the Institute) 14 x $25 000		350 000
- Station Wagon (same number plus 4 for WHO Professional staff) 18 x $15 000		270 000
	Sub-total	620 000
4. Local Costs (For training courses plus field work allowances)		1 573 700
	Sub-total	1 573 700
	Grand Total	18 135 000

SUMMARY COSTS - MALARIA CONTROL PROGRAMME

		Costs ($)
1. Personnel		780 000
	Sub-total	780 000
2. Supplies and Equipment		
2.1. Antimalarial drugs		
- Chloroquine (150 mgm base)		660 000
- Primaquine (15 mgm base)		396 000
- Sulfadoxine (500 mgm) + Pyrimethamine (25 mgm)		3 300
	Sub-total	1 059 300
2.2. Insecticides and Spraying Equipment		
- DDT		1 602 000
- Malathion		11 200 000
- Temephos		250 000
- Sprayers, Hudson		675 000
	Sub-total	13 727 000
2.3. Laboraroty Supplies & Equipment		
- Microscopes, etc.		240 000
- Equipment and Supplies		135 000
	Sub-total	375 000
3. Transport		
- 14 pickups (at $25 000 each)		350 000
- 18 station wagons (at $15 000 each)		270 000
	Sub-total	620 000
4. Local Costs (Training, field allowances)		1 573 700
	Grand Total	18 135 000

A substantial contingencies provision is required for a country-wide control programme of the major health hazard (Malaria) and the balance of estimated costs (out of the total of US$ 20 million in the estimates statement) has been retained for the purpose.

III. F. 3. Control of Diarrhoeal Diseases

Diarrhoeal Diseases, a major health problem in Afghanistan, are complex and involve deep-rooted cultural and behavioural factors in addition to the vitally important factors of poor sanitation, inadequacy of health personnel, particularly in rural areas, insufficient or inaccessible health facilities, inadequate reporting and supervisory facilities, insufficient supply of ORS or inadequate knowledge about its use. Poor personal and communal hygiene add to the complexity of the problems as, indeed, they also contribute to incidence

of other communicable diseases. Other major contributory factors are lack of sufficient safe drinking water (only about 8% of the population has access to safe drinking water, figures being much worse in the rural areas), low literacy rate, especially among women and consequently poor standards of health education. A national programme for Control of Diarrhoeal Diseases (CDD) was started in Afghanistan in 1983 aimed at 20% reduction in incidence, within five years, with a 50% ORS access rate and 30% ORT use rate. Case management, epidemic control, and strengthening of MCH and environmental health facilities form the strategies for achievement of these objectives. With the disturbed situations, however, limiting operational activities to Kabul and surrounding areas, the ongoing programme cannot be considered to be effective.

Among the refugee population in Pakistan, diarrhoeal disease control programme, case management, MCH care and epidemic control and accessibility to ORS and awareness of its use, has brought the incidence considerably lower. Even so, these diseases remain amongst major and priority health problems. Control of diarrhoeal diseases requires a multi-disciplinary approach.

Close coordination and support of UNICEF has been available, particularly in provision in 1981, of equipment and supplies for local production of one-litre ORS sachets. Production in the National Avicenna Pharmaceutical Institute in Kabul also started in 1982 (estimated output 1-2 million ORS packets a year). Two campaigns - in 1984 and 1985 - were conducted distributing 340 000 and 2 million ORS packets, respectively, in Kabul during the diarrhoea prevalence season. 600 000 ORS packets are reported to have been distributed in the provinces also. These activities have been supported with seminars for epidemiologists, pediatricians and other para-medical and medical staff aimed at training in oral rehydration therapy. A national Diarrhoea Training Unit has also been established in Kabul in 1986, with WHO assistance, and a public health education campaign assisted with the publication, provision and distribution of pamphlets, books and leaflets and media programmes.

During the repatriation of refugees, and the recovery and rehabilitation phases, the same multi-disciplinary approach, in close cooperation with UNICEF, and NGOs will be exercised for the CDD component of the Health Programme.

An estimated cost of US$ 6.50 million has been provided in the total estimates for this component of the programme.

III. F. 4. Tuberculosis Control

The basic requirements in a tuberculosis control programme viz., not only the capability to deliver adequate chemotherapy to detected infectious cases of the disease, but also to be able to ensure proper dosage, regularity of intake and adequate duration of treatment to achieve cures or render patients non-infectious - would be difficult to meet in the context of the Afghan Recovery and Rehabilitation Programme in either of the two envisaged phases. In fact, implementation of an effective tuberculosis treatment policy and programme or modification of an ongoing practice of inappropriate treatment, would pose immense organisational problems, particularly in the initial phase of repatriation and rehabilitation.

I. INTRODUCTION

The UN Humanitarian and Economic Assistance Programmes related to Afghanistan to be implemented by the UN Coordinator contain an important component related to health. It need hardly be emphasised that in situations like those prevalent in Afghanistan, be they in relation to the Refugees, the internally displaced or the population in areas under the Afghan Government's control, health in all its facets - promotive, preventive and curative - is a major casualty. By the same token, it requires a massive effort to rebuild and rehabilitate the health infrastructure in order to encourage refugees to return, to provide essential health services in the devastated areas and to generally develop and strengthen the national health services for the long-term.

The World Health Organisation, as the UN Specialised Agency in the health field, has prepared draft projects, outlining programme contents and cost impact, for both the short-term and long-term activities in the health sector within the UN Humanitarian and Economic Assistance Programmes related to Afghanistan. These programmes and projects have been prepared, understandably, within the constraints of lack of latest and reliable information about the extent of recovery and rehabilitation that may be required. Nevertheless, programmes are based on the experience and expertise of WHO and give a reasonably accurate outline of the health programmes that will be required. The need for flexibility and modifications in the light of emerging information or situations should therefore be understood.

These programmes are presented to the Donor Community as background material within the appeals of the UN Secretary General and the UN Coordinator for Humanitarian and Economic Assistance to Afghanistan.

Until conditions stabilize in the Recovery and Rehabilitation phase and a well-planned, well-structured tuberculosis control programme can be implemented through national health services, the smear positive cases will constitute priority for treatment. Attention to smear-negative but culture positive cases will have to be deferred until facilities for culture or x-ray examinations can be organized. Febrile, acute, miliary or tuberculous, meningitis cases, even without bacteriological confirmation as well as children at special risk (contacts of active cases), will also be included in the initial programme activities.

According to figures so far available, incidence of tuberculosis in Afghan population is one of the highest. It is estimated that as many as 150 out of 100 000 population would be smear positive. In the reasonably controlled situation of Afghan Refugee Health Programme in Pakistan and availability of health services in Iran, the figures among returnees may not be that high but the stresses and strains of return journeys, nutritional deficiencies and disruption in continuity of regimen of treatment, would push the patient load considerably higher. Besides, the population in locations of return, where preventive and curative facilities are not likely to be available, would present high figures of incidence and also increase potentials of infection and reinfection.

Domiciliary/ambulatory treatment, if properly supervised and controlled, has proved no less successful than admission to hospitals or sanatoria. Tuberculosis control measures, with ensured regularity and duration, can be made effective even under conditions likely to prevail during repatriation. Basic health units, dispensaries or temporary health facilities at transition points, can be effectively used to deliver and continue such a programme.

A quick assessment can identify the total patient load. A large number of community health/PHC workers in the Afghan Refugee Health Programme have already been trained in case detection techniques. Their numbers and quality can be improved by imparting 1-2 weeks training, to enable them to recognize symptoms and take smears for examination at the network of microscopic centres established at the basic health units/health points. The latter can also serve the purpose for malaria detection activities, thus facilitating integration of health programmes at the periphery and full utilisation of available manpower.

For chemotherapy to be successful, an effective drug regimen, understood and accepted by the patient, uninterrupted and for a full prescribed period - one year, eight or six months, as applicable - will be instituted. An effective defaulter tracking activity would be an essential feature of the programme.

Six essential antituberculosis drugs, in various combinations, are used for chemotherapy. These are:

- Isoniazid (tablets of 100-300 mgm)
- Rifampicin (tablets or capsule of 150-300 mgm)
- Pyrazinamide (tablets of 500 mg)
- Streptomycin (powder for injection 1g)
- Thioacetazone (tablets of 50 mg)
- Ethambutol (tablets of 100, 400, 500 mg) (replacing PAS)

Both daily and intermittent administration can be used according to prevalent circumstances.

Anticipated patient/workload

Latest estimates available for annual risk of infection in Afghanistan showed a rate of 3.5% (1978) with no tendency of decrease. This gives an annual incidence of 2 smear positive cases of tuberculosis per 1000 population (all ages).

The prevalence now, because of the disorganised conditions, may be 4 per 1000 population, notwithstanding the fact that the incidence and cure rate in the refugee camps in Pakistan may be lower. Because of the disruption, disorganisation and stress that will follow in the wake of repatriation, resettlement, etc., and in view of large scale destruction anticipated in areas of resettlement, a higher incidence for planning purposes is justified. Calculating on the basis of a population of 13 million (10 million in Afghanistan and 3 million returnees) therefore, an estimated 50 000 positive cases plus another 40 000 cases occurring in the 18-month period, would be the patient load. With reasonably organised facilities, it would be possible to detect, initiate, or continue, treatment for at least 30 000 smear positive cases during this period. Smear negative cases may be in the same proportion, but with meagre culture and x-ray facilities, the likely number in this category would be 10 000.

Resources Required

1. Case finding and diagnosis

- Smear Positive Cases
  At least 10 symptomatic suspects need to be screened and three sputum samples collected and examined in order to detect one smear positive case. The cost of one examination (sputum container, slides, reagents) is $0.135. Total for 900 000 examinations (to find 30 000 cases) would, therefore, be $121 500.

- For smear negative cases, when x-ray examination is possible (particularly in symptomatic young children who cannot produce sputum), with a unit cost of $1.50, the total estimated cost (per 10 000 case detection) $150 000.

2. Chemotherapy

   The cheapest quickest and reasonably effective 8-month course costs $30 while 6 months intermittent therapy costs $43.30. The total costs for treating 40 000 patients, therefore, will be $1.2 - $1.7 million. With added costs for transportation and distribution total estimated cost would be $1.8 -2.5 million.

3. Treatment Monitoring

   Smear positive cases require 3x2 sputum examinations during the course of treatment. Costs for this would be $24 000. Additionally, a cost of $30 000 would accrue for providing at least two x-ray examinations for cases diagnosed by this means.

4. Training Costs

- Training of staff at district level - $125 000

- Training of supervisory and managerial staff (an 18-month training course), including transportation and travel - US$ 270 000.

5. Central Laboratory

This facility will be required mainly to guide bacteriological work, supervise quality of field work, training and retraining of health personnel in TB control. Initial equipment and suppplies for an 18-month period will cost $120 000.

6. Other Capital Costs

Microscopes (about 200 at $1000 each) - $200 000.
Transport (20 land rovers - at $18 000 each and 80 motor cycles at $1 630) - $490 000.
Operational costs for 18 months - $ 500 000.

Wages of staff, other costs for patient care (hospital admission, etc.), administrative and management costs are not included.

SUMMARY OF EXPENDITURES - TB CONTROL PROGRAMME

(INITIAL REPATRIATION AND REHABILITATION)

		US$
Case Finding and Diagnosis		271 500
Chemotherapy Drugs		1 800 000
Treatment Monitoring		54 300
Training		125 000
Transport and Travel		270 000
Central Laboratory		120 000
Microscopes		200 000
Vehicles		490 400
Operational Costs		500 000
Total		3 831 120
Miscellaneous (10%)		383 120
	Grand Total	4 214 320

Note:

Estimated costs, reflected above, are for the initial phase of activities. Balance of funds included under this heading (i.e. total of US$ 12 million) will be required for strengthening and continuity of the programme during Recovery and Rehabilitation phase.

III. F. 5. Prevention of Blindness

Incidence of eye disease leading to blindness, mainly Trachoma and Vitamin A Deficiency in children under 10 years and cataract amongst adults, is known to be high in the Afghan population. According to figures collected in Afghanistan itself in 1984, some 25% of preschool children (under 5 years of age) and 10% of school children (aged 6-19) were reported to be suffering from Trachoma. Incidence of Vitamin A deficiency leading to Xeropthalmia is also known to be quite high. A similar situation would obtain among the refugees although, through the preventive and curative aspects of the Refugee Health Programme, the situation may have been reasonably controlled. Even so, unhygienic conditions, disruption expected during the repatriation phase and an unsatisfacotry state in the areas of return, would result in resurgence and high incidence.

Simultaneous action will be required to strengthen the established centres in Kabul, Afghanistan - notably the Noor Institute in Kabul - as well as making provision for prevention, control and curative measures.

Activities

1. Taking the above facts into consideration, an incidence of about 20-30% among children under 10 years can be estimated. According to established control criteria, an incidence of 20% and over calls for blanket treatment of the population at risk. In a population of 13 million, about 25% (i.e. 3/1-2 million) are expected to be children under 10 years of age. Working on an average incidence of 20% amongst them, a total of 700 000 will require blanket treatment with tetracycline ointment. The effective regimen of intermittent application for 5 days per month over a period of 6 months and working on one tube of the ointment per individual, at a cost of 10 cents per tube, would entail an expenditure of US$ 100 000.

2. To control Vitamin A deficiency, provisions will have to be made for roughly 50% of the total estimated 3/1-2 million children. Approximately 2 million capsules twice a year, i.e., 4 million capsules will be required at a cost of approximately US$ 2 for 100 capsules. The total cost for a year works out to US$ 80 000 amounting to a total of US$ 430 000 for the programme period, including transportation and distribution costs. This part of the programme can be combined for delivery with the trachoma blanket treatment. Shelf life of both the ointment and the vitamin is reasonably long, given reasonable storage facilities, i.e., avoiding too much exposure to direct light, heat, etc.

3. Surgical treatment for trichiasis cases, ocular trauma and cataracts will also have to be provided for. Standardised surgical instrument sets for both cataract and trichiasis surgery are available at US$ 600 and US$ 200 per set, respectively. A total of 100 sets for each will, therefore, require a total provision of US$ 80 000. Additional provision of US$ 20 000 will be required for other supplies like syringes, local anaesthetics, eyeshields, etc. An additional outlay of US$ 100 000 would be required for the organisation of surgical teams, transportation, etc., bringing the total expenditure under this head to US$ 200 000.

4. Training of personnel of various categories at treatment centres as well as for preventive/control measures and organisation of workshops for this purpose will require an expenditure of US$ 100 000.

5. Costs for providing reading glasses for the needy adults in the population are also provided for. Ageing individuals may be in dire need of such aids for their day to day work. A sum of US$ 50 000 has been included for this purpose.

6. The exact nature and extent of strengthening facilities for Noor Institute can only be determined after the initial assessment mission has completed its work. For this purpose and training/retraining of personnel and reorganisation of its activities an estimated provision of US$ 100 000 is also included.

SUMMARY, BLINDNESS PREVENTION PROGRAMME

		US$
1.	Tetracycline eye ointment	100 000
2.	Vitamin A Supplies and Distribution	430 000
3.	Surgical treatment of Trichiasis and Cataract	
	- Instruments	80 000
	- Surgical supplies	20 000
	- Surgical teams and transportation	200 000
4.	Training of personnel	100 000
5.	Provision of reading glasses	50 000
6.	Strengthening of Noor Institute	100 000
	Total	1 080 000

This is marginally above the estimated costs (US$ 1.00 million) included in the original appeal.

III. F. 6. Rehabilitation of the Disabled

It can be estimated that about 10% of the total population being catered for will fall in the category of disabled. This includes disabled other than strife-wounded and amputees - like deaf, blind and mentally retarded. The rehabilitation programme should, therefore, be designed in order to meet the needs of all these categories. In the initial recovery and resettlement phase, the needs of the wounded, disabled and amputees will take priority while the needs of the other categories of disabled will be covered through a wider, long range programme of rehabilitation.

WHO advocates rehabilitation as an integral component of the Primary Health Care Programme and implementation of a "community-based rehabilitation" programme. This is even more realistic for conditions expected in Afghanistan, and the areas to which refugees are likely to return. Under such conditions it may not be practicable, at least in the initial stages, for centrally based programmes to reach the needy at the periphery.

It is proposed that this programme should be initiated well before repatriation starts rather than await the refugees' return to settlement areas.

The programme component will include the following activities:

- An assessment of needs both amongst refugees and the internally displaced population to identify and establish numbers, categories and locations where the programme is to be operative. This can be done quickly, within

4-6 weeks by working on lines detailed in the WHO Manual mentioned below. The cost of this mission would be $10-12 000.

- Identification of skills available within the Refugees Health Programmes and in Afghanistan and selection of individuals for training. The persons identified would be trainers of PHC workers, and would receive training for 2-3 months. The workers themselves will be given short courses of 2-3 weeks to enable them to identify needs and learn skills required for a community-based rehabilitation programme.

- Translation of the WHO manual "Training in the Community for People with Disabilities" into Dari(Farsi)/Pushto. This translation will take about three months and is estimated to cost $10 000. It should be possible to find suitable translators in Kabul/Afghanistan.

- Support to the Kabul Institute for the Disabled by training/retraining of the present staff, strengthening staff position and provision of requisite equipment. Cost estimates can be projected after the initial assessment mission suggested above has completed its work.

- Establishment of regionalised orthopaedic workshops utilizing simple techniques rather than relying on too much machinery or sophisticated appliances which will require import of expensive raw material or finished parts from abroad. The latter are costly, not easy to obtain and would present difficulties in storage and distribution in the unsettled conditions. Urgent needs can be met in this way, but emphasis must remain on a long term self-reliant programme.

  Use of thermoplastic material with simple apparatus or use of aluminium is advocated, both of which are easily manipulated. Appliances can thus be produced by technicians trained for 4-6 months and supervised through periodical visits by better trained persons. Each such workshop, apart from cost of personnel, can be equipped with simple appliances (oven, rivetting appliances, etc.) not dependant on availability of reliable electric power. Total cost of each workshop will be approximately $2 000 and a network of some 20 workshops, spread over needy areas, would be able to meet the total needs.

- During the initial stages of the programme and in order to cope with the large number of wounded and mine casualties effective support will have to be provided to surgical units dealing with these casualties followed by rehabilitation activities. Considerable provision will have to be made for this purpose and for the total programme.

- Sufficient number of selected individuals with requisite basic qualifications will be trained to cater for the needs of other categories mentioned in the opening paragraph.

<u>Note:</u>

The budgetary forecasts included for this component of the Programme, i.e., $7.7 million for the first phase and $1.0 million for the second phase

with a total provision of $8.7 million would be adequate to make this programme component operational and to be merged into the national programme of rehabilitation at a later stage.

Given the importance and priority of this programme and the need for a comprehensive plan, a special sub-committee has been constituted with representation from the Social Development Centre, Vienna, WHO, ILO, UNHCR and UNICEF. The sub-committee is to formulate a plan for a comprehensive, integrated and community-based rehabilitation programme for the disabled for the short-term as well as long-term needs.

III. F. 7. Nutrition Support

Malnutrition among the child population is estimated to be reasonably high and is expected to present a major problem during the initial phases of the assistance programme. While WFP will cater for overall food requirements, there will be need for supplementary feeding centres, nutrition monitoring and evaluation. For Nutritional support, therefore, a sum of US$ 6.00 million has been included in the total estimates.

III. G. Rehabilitation and Equipping of 50 Hospitals

As mentioned in the introductory remarks, it is planned to undertake a health needs and services assessment survey as soon as possible. The information so collected will facilitate determination of needs in respect of the 50 hospitals that may need to be equipped and rehabilitated. Estimates for this assistance can be worked out depending on services and facilities available and required to be provided, position in the referral chain, bed-strength, staffing pattern, location, etc. These estimates will include cost of equiping/rehabilitating various departments like radiology, operating rooms, laboratories as well as other supportive departments.

Costs are available with WHO of these various facilities. For example, a radiology department can be re-established/rehabilitated with the Basic Radiology System (BRS) - the kind now procured for Iran by UNHCR - fully installed costs of each unit, with accessories, being $65 000. Films, storage facilities, dark room opertions, etc. will require additional funds. Training of personnel will be an essential feature of this component. An auxiliary health worker with 3-4 weeks training can learn the basic operation of the unit, whereas a middle level health worker (nurse/auxiliary nurse) with a 2-3 months training, supervised by a visiting qualified radiologist from the District/Region, can make an effective team for a Basic Radiology Department. Standard WHO manuals for training of different categories, e.g. "Manual of Radiographic Techniques", "Manual for Dark Room Operations" and "Manual for General Medical Doctors" (not Radiologist), translated where required, and made available for training of personnel, would make such a unit fully operational.

Similar costs in respect of other supporting facilities like Laboratory, Operating Room, Physiotherapy, Vehicles, etc. can be worked out once information, referred to above, is available. The total estimated costs for this purpose will be US$ 10 million sread over both the phases.

III. H. Rehabilitation of Nursing School

In the field of health manpower development, the most critical area is that of availability of qualified nurses in the health system. Hospitals at various levels are critically depleted for their own staffing needs and also to provide referral support to the primary health care system. MCH services are also severely handicapped by this shortage. Socio-cultural traditions in Afghanistan are an inhibiting factor for women joining the nursing profession in significant numbers.

Special attention will, therefore, be required to retain and strengthen the quality of available nurses. Programmes for training and retraining will be given special emphasis and put into operation urgently. These activities will be required at district/regional levels to meet the needs of returnees as well as centrally in Kabul/Afghanistan. The existing schools of nursing are known to be operationally weak under the existing circumstances, particularly, those located in the provinces. The latter may even be destroyed or closed down.

Adequate budgetary provision is, therefore, required for training programmes for nurses and for strengthening/rebuilding of the nursing schools. An estimated cost of US$ 3.00 million has been included in the budgetary costs for this purpose.

II. BACKGROUND AND WHO'S ROLE

The health status of the population in Afghanistan is that of one of the Least Developed Countries. High rates of infant, under-five child and maternal mortality, malnutrition and a high incidence of communicable diseases present depressing health indices. Infant mortality rate is estimated at 189 per 1000 live births and under-five mortality rate at 329 with a life expectancy of only 38 years at birth. According to a study undertaken in 1973-74, the maternal mortality rate was found to be more than 100 per 10 000 births, four and a half to five times more than that of other developing countries. Malaria, diarrhoeal and respiratory diseases including tuberculosis and eye diseases are major health problems. Safe drinking water is available to a very small percentage, and the existence of poor environmental health conditions and low literacy rates, especially among women, are highly conducive to high morbidity, infirmity and mortality.

The deterioration of the national infrastructure in recent years and displacement of a high proportion of the population, both within and outside the country, have compounded the problems and the health sector is no exception. Many of the operational disease control programmes have been severely disrupted. The majority of the population have little or no access to preventive and curative health care. The fighting over the past years has added the additional burden of the disabled. Health manpowér has been severely depleted either due to interruption of training programmes or trained manpower having left the country. The situation, gloomy as it is, will require a massive effort to rebuild the health infrastructure, strengthen disease control programmes and give effective technical and material support to rehabilitate and develop the national health system.

WHO's regular programme of technical cooperation in Afghanistan has been a sizeable one with a biennial budget for 1986-87 amounting to over five million US dollars. Salient features of this programme are: health systems infrastructure development based on primary health care approach; disease prevention and control; health manpower development; strengthening of training institutions and programmes within the country and award of fellowships for training abroad. In recent years, project activities particularly disease control, have been restricted to the Kabul area.

Since early 1988, WHO has actively participated in joint UN-agency planning for preparation of assistance for the Afghan refugees' return to their country as well as recovery and rehabilitation within Afghanistan. A process of situation assessment and project review in close consultation with technical divisions at WHO Headquarters and WHO Eastern Mediterranean Regional Office has been initiated. Technical assistance planning has been done in coordination with UNHCR, UNICEF, the League of Red Cross and Red Crescent Societies and non-governmental agencies.

A projected programme of technical assistance and support was incorporated in the UN Secretary General's appeal for Humanitarian and Economic Assistance Programmes relating to Afghanistan and also included in the appeal to the donor countries by the Coordinator for United Nations Humanitarian and Economic Assistance to Afghanistan, PRINCE SADRUDDIN AGA KHAN. A Needs and Services Assessment mission is now planned in order to establish basic data

:S FOR THE HEALTH SECTOR (in US$ millions)

	Commodity Needs			Technical Assistance			Capital Assistance		
	Relief-Rehab	Rehab-Recovery	Total	Relief-Rehab	Rehab-Recovery	Total	Relief-Rehab	Rehab-Recovery	Total
	19.00	68.00	87.00						
:				2.50	5.00	7.50			
				2.50	5.00	7.50			
70 :es							8.00	12.00	20.00
1							5.00	10.00	15.00
Programmes							23.20	51.00	74.20
							5.00	15.00	20.00
							5.00	15.00	20.00
e							1.50	5.00	6.50
							2.50	9.50	12.00
ion							0.50	0.50	1.00
the Disabled							7.70	1.00	8.70
							1.00	5.00	6.00
uipping							3.00	7.00	10.00
ursing							1.00	2.00	3.00
	19.00	68.00	87.00	5.00	10.00	15.00	40.20	82.00	122.20

V. AFGHANISTAN ASSISTANCE AND REHABILITATION PROGRAMME
INFORMATION ON HEALTH INFRASTRUCTURE

With a view to providing a basis for the preparation of a health sector component of the UN Programme for Humanitarian and Economic Assistance for Afghanistan, a set of forms have been developed for the collection of data on the existing health facilities and to establish needs. The information to be collected now will primarily be to identify urgent health needs of returnees and of the local population which can be met within the immediate recovery and settlement period. Further data collection through in-depth studies will be required at a later stage, for preparing a detailed programme for the strengthening and rehabilitation of the national health system.

Information Sheet for District gives an overview of the situation as regards the hospitals, health centres and subcentres requiring rehabilitation, the resources available and expected increase in the number of beneficiaries of the health services.

For each type of health facilities, supplementary data on the range of services provided, availability and conditions of the equipment etc., deficiencies in the staff complements and major health problems can be obtained through *FORM A* for Hospitals, *FORM B* for Health Centres and *FORM C* for Subcentres. A photograph of the facility, if attached to the form to which it relates, will greatly enhance the meaningfulness of the information contained in the form.

It is expected that these forms will be completed by appropriate sources, government agencies, NGOs etc. and that though precise values may not be available, at least rough estimates can be provided.

Forms, once completed, should be sent to:

Emergency Preparedness and Response Unit
Attn Dr Mumtaz Husain (WHO Consultant)
World Health Organization
Avenue Appia
1211 Geneve 27
Switzerland

AFGHANISTAN ASSISTANCE AND REHABILITATION PROGRAMME
INFORMATION ON HEALTH INFRASTRUCTURE

INFORMATION SHEET FOR DISTRICT

[This sheet should be completed for each district in the Region]

1. REGION ________________ 2. PROVINCE ________________

3. DISTRICT ________________

4. NUMBER OF VILLAGES ________________

5. ESTIMATED POPULATION ________________
   - NOW ________________
   - EXPECTED RETURNEES ________________

6. ROUGH PERCENTAGE OF PRESENT POPULATION
   - CHILDREN LESS THAN 5 YEARS ________________
   - ADULT MALES OF 15 YEARS AND ABOVE ________________

7. NUMBER OF HOSPITALS IN THE DISTRICT ________________

8. NUMBER OF HOSPITALS FUNCTIONING ________________

   FOR EACH OF THE HOSPITALS FUNCTIONING COMPLETE FORM A

9. NUMBER OF HEALTH CENTRES IN THE DISTRICT ________________

10. NUMBER OF CENTRES FUNCTIONING

    FOR EACH OF THE HEALTH CENTRES FUNCTIONING COMPLETE FORM B

11. NUMBER OF SUB CENTRES IN THE DISTRICT ________________

12. NUMBER OF SUB CENTRES FUNCTIONING ________________

    FOR EACH OF THE SUB CENTRES FUNCTIONING COMPLETE FORM C

13. NUMBER OF VILLAGES WITH VILLAGE HEALTH WORKERS ________________

14. NORMAL FUNCTIONS OF VILLAGE HEALTH WORKERS
    IN THE DISTRICT

15. NUMBER OF VILLAGES WITH TRADITIONAL BIRTH
    ATTENDANTS

____

____

____

____

____

16. NUMBER OF TBAs

- TOTAL ______________
- TRAINED ______________

17. ARE THERE SERVICES FOR THE CARE OF DISABLED YES/NO

18. IF YES, HOW AND WHAT SERVICES ARE USUALLY GIVEN

____

____

____

19. AVAILABILITY OF VARIOUS RESOURCES IN VILLAGES

RESOURCES	APPROXIMATE NUMBER OF VILLAGES COVERED	DETAILS OF USUAL ACTIVITIES
- Drug Distribution Centres or Pharmacists		
- Traditional Medical Practitioners		

20. COMMON SOURCES OF WATER SUPPLY ______________

21. TOILET FACILITIES OFTEN USED ______________

22. PRIORITY HEALTH PROBLEMS IN THE DISTRICT

(List 5 problems in order of priority)

____

____

____

____

____

23. MAIN PROVIDER OF HEALTH SERVICES:

24. NAME AND CONTACT ADDRESS OF PERSON COMPLETING THIS FORM

____

____

____

____

25. DATE OF COMPLETION ______________________________

FORM A

INFORMATION SHEET FOR HOSPITALS

[This sheet should be completed for each public or private hospital in the district]

1. REGION ____________________
2. PROVINCE ____________________
3. DISTRICT ____________________
4. MAIN SOURCE OF SUPPORT ____________________

5. NAME OF HOSPITAL ____________________
6. LOCATION ____________________

7. NUMBER OF BEDS ____________________
8. SERVICES PROVIDED BY SPECIALTY
   - MEDICINE YES/NO
   - SURGERY YES/NO
   - PEDIATRICS YES/NO
   - OBS. & GYN YES/NO
   - LONG TERM CARE YES/NO
   - OTHERS (SPECIFY) ____________________

9. EQUIPMENT, TRANSPORTATION, ESSENTIAL DRUGS AVAILABLE

TYPE	AVAILABLE	SATISFACTORILY FUNCTIONING
X-RAY Facilities		
Laboratory Facilities		
Surgical Facilities		
Essential Drugs		
Ambulance		
Telephone		
Others (Specify)		

10. STAFF COMPLEMENT

CATEGORY	AUTHORIZED POSTS	FILLED POSTS Male	Female
Physician			
Surgeons			
Nurses			
Other Specialists (Specify)			
______________________			
______________________			
______________________			
Other Paramedical Staff (Specify)			
______________________			
______________________			
______________________			

11. FACILITIES FOR TRAINING HEALTH AND MEDICAL PERSONNEL YES/NO

12. TRAINING PRESENTLY DONE (DESCRIBE)

____

____

____

____

____

13. NUMBER OF OUTPATIENTS PER DAY ______________________

14. NUMBER OF ADMISSIONS PER DAY ______________________

15. LIST FIVE MAJOR HEALTH PROBLEMS AMONG

- OUTPATIENTS ______________________________

  ____

  ____

  ____

  ____

- ADMISSIONS ______________________________

  ____

  ____

  ____

  ____

16. REFERRAL FACILITIES

Referral from this hospital to ______________________________
Name of Hospital

____
Location

17. SUPERVISION OF HOSPITAL CARRIED OUT BY

______________________________ ______________________________
Name Designation

18. INFORMATION SHEET COMPLETED BY:

______________________________ ON ______________________________

FORM B

INFORMATION SHEET FOR HEALTH CENTRE

1. REGION ______________________
2. PROVINCE ______________________
3. DISTRICT ______________________
4. MAIN SOURCE OF SUPPORT ______________________

5. NAME OF HEALTH CENTRE ______________________
6. LOCATION ______________________

7. NUMBER OF VILLAGES COVERED ______________________
8. ESTIMATE OF POPULATION COVERED:
   - NOW ______________________
   - EXPECTED RETURNEES ______________________

9. MANPOWER IN THE HEALTH CENTRE:

CATEGORY	AUTHORISED POSTS	FILLED POSTS M	F
Doctor			
Nurse			
Sanitarian			
Feldscher			
Male Nurse			
Village Health Worker			

10. SERVICES GIVEN

. MCH	YES/NO
. TB	YES/NO
. Malaria	YES/NO
. Environmental Improvement	YES/NO
. Eye Diseases	YES/NO
. Diarrhea	YES/NO
. Immunization	YES/NO
. Rehabilitation	YES/NO
. Case Detection (Microscope or Other Lab. Exam)	YES/NO
. Others	YES/NO

11. AVERAGE NUMBER OF OUTPATIENTS PER DAY

12. MAJOR HEALTH PROBLEMS AMONG OUTPATIENTS

. Fever	YES/NO
. Cough	YES/NO
. Headache	YES/NO
. Diarrhoea	YES/NO
. Abdominal pain	YES/NO
. Vomiting	YES/NO
. Skin Diseases	YES/NO
. Eye Problems	YES/NO
. Injuries	YES/NO
. Others (Specify)	YES/NO

13. OUTREACH FACILITIES/SERVICES, IF ANY YES/NO

14. IF YES, BY WHOM PROVIDED ______________________

15. AVAILABILITY OF TRANSPORT FACILITIES FOR REFERRAL YES/NO

16. IF YES, TYPE OF AVAILABLE TRANSPORTATION ______________________

17. INFORMATION PROVIDED: BY ______________________

ON ______________________

necessary for detailed programme planning and inititate a management process in support of programme components being implemented by governmental and non-governmental agencies.

Major components and programme activities in the health sector, planned in the light of information so far available, are detailed in the text that follows.

The main features of the health sector programme are:

- rehabilitation of health facilities and their equipment;
- health manpower needs for staffing of the health services, training, retraining and recruitment of health personnel of all categories;
- epidemiological surveys, programme planning for disease prevention, treatment and control;
- re-establishment of the logistic and supportive mechanisms required to sustain the restored health services.

The programme will technically support the relevant authorities and supportive agencies in the enormous task of rebuilding, establishing rational and feasible policies, strategies and plans for implementation in the medium-term and to strengthen capacities of communities, district and national authorities to plan and manage the work of the health sector. Activities, through this process of recovery and rehabilitation, can then progressively move to development of an operational health care delivery system to meet the health needs of all Afghan people.

While the programme outline includes specific disease control projects, this has been done for ease of costing of different programme contents. The concept of an integrated approach based on primary health care will, however, be followed from the very beginning and vertical programme implementation avoided, as far as possible, so that integration with national health care delivery programmes is facilitated during the recovery and rehabilitation phase.

The attached documents show:-

- the salient areas of action within the programme component;
- project costs for both the short-term and long-term programmes;
- details, as far as it is possible to determine, of activities within the programme content, technical and material resources required and costs involved under each heading;
- the total estimated cost of the health sector programme for the Relief and Rehabilitation (18 months) phase is estimated at US$ 64.20 million and for the long-term Rehabilitation and Recovery phase at US$ 160.00 million. The overall total covering both phases which may overlap or run simultaneously is estimated at US$ 224.20 million.

FORM C

INFORMATION SHEET FOR SUB CENTRE

1. REGION ______________________

2. PROVINCE ______________________

3. DISTRICT ______________________

4. MAIN SOURCE OF SUPPORT ______________________

5. NAME OF HEALTH CENTRE ______________________

6. LOCATION ______________________

7. NAME OF SUB CENTRE ______________________

8. LOCATION ______________________

9. NUMBER OF VILLAGES COVERED ______________

10. ESTIMATE OF POPULATION COVERED:
    - NOW ______________
    - EXPECTED RETURNEES ______________

9. MANPOWER AVAILABLE:
    - Feldscher ______________________
    - Male Nurse ______________________
    - Village Health Workers ______________________
    - Traditional Birth Attendants ______________________

10. SERVICES GIVEN
    - MCH YES/NO
    - TB YES/NO
    - Malaria YES/NO
    - Environmental Improvement YES/NO
    - Eye Diseases YES/NO
    - Diarrhea YES/NO
    - Immunization YES/NO
    - Rehabilitation YES/NO
    - Case Detection (Microscope or Other Lab. Exam) YES/NO
    - Others YES/NO

11. AVERAGE NUMBER OF ATTENDANCES PER DAY ______________________

12. OUT REACH SERVICES IF ANY YES/NO

13. IF YES, BY WHOM PROVIDED ______________________

14. MAJOR HEALTH PROBLEMS IN THE AREA (LIST 5 PROBLEMS IN ORDER OF PRIORITY)

____

____

____

____

____

15. INFORMATION PROVIDED: BY ______________________

ON ______________________

III. PROGRAMME CONTENTS

III. A. Supply of Drugs and Medicines

The drugs and medicines requirements will be the largest budget-consuming component of the health sector programme. The requirements for specific disease control programmes (e.g. Malaria, Tuberculosis, Immunization, etc.) are given under their relevant headings. The following requirements are to cater for making health centres and sub-centres operational during the initial repatriation and resettlement phase. The requirements of most of the 70 basic health centres and 76 sub-centres mentioned under this budget-line in the Health Sector overall estimates, are also covered by what follows:-

1. It is estimated that 13 million people, the population for which all calculations are being made, will require health care at least 3 times each during the period. This works out to 39 million outpatients consultations and approximately 3 million admissions.

2. For simple outpatient care to be done by Primary Health Care workers, the contents of a standard WHO Emergency Kit will be adequate. The latest price estimate is $450 per basic kit (including 25% for freight) sufficient for 1 000 consultations.

3. For outpatient care by higher grade health workers, e.g. doctors and for simple inpatient care, the Supplementary Emergency Health Kits will be required. The cost of each kit, adequate for 10 000 consultations (including 6-8% admissions) will be $3 625 including 25% freight. Costs for this purpose, therefore, are:

   39 million consultations will require:-

39 000 basic kits		-$17 550 000
39 00 supplementary kits		-$14 137 000
	Total Cost	-$31 687 000

(Works out to an average of US$0.83 per consultation).

4. An additional 30%, i.e. $950 775 will be required for dressings and materials which are not drugs (surgical material, syringes, etc.).

   The cost of US$ 32 637 775 indicated above (US$ 31 687 000 + US$ 950 775) will be met out of the total of US$ 87 million shown against the item on the total costs proforma. The balance will be spread over both phases of resettlement, recovery and rehabilitation for provisions and maintenance of essential supplies and equipment.

5. To make other health centres and sub-centres operational, it will be adequate to provision stocks based on the WHO lists of essential drugs for various categories of health units. Depending on the number in need of total stocking and those needing only partial strengthening, costs can be worked out. This expenditure will relate to item 4 on the "Total

Planning

Initial planning is already underway. Programme outlines and estimated costs were prepared and included in the appeal to the donor community by the UN Secretary General and the the UN Coordinator for Afghan Recovery and Rehabilitation. More detailed planning has also been done and is included in the present document. All this, of necessity, had to be done in the light of scant - and in some cases, unreliable - information. Plans so far submitted, therefore, have to be flexible so as to incorporate any amendments that may be necessary in the light of more concrete information that may become available.

Management

The health sector programme activities, in the initial stages, are seen as a combination of working with NGOs and other agencies active in the field as well as implementation through local (national) authorities in areas under their control. The dual approach for implementation would be necessary until integration is possible into the countrywide health programmes. A management component is being provided for this purpose.

It is known, however, that NGOs because of their varying approaches and resource and funding potentials may have objectives which may not be in conformity with UN policies and concepts, nor in line with national health development plans. It would, therefore, be essential for WHO, with its available technical expertise, to play a key role in coordinating and actively supporting the NGOs in implementation of health programmes.

It will also be necessary to establish an active collaborative mechanism to bring together other UN agencies active in health and health-related fields. UNICEF and UNHCR are the two major agencies but active collaboration with other agencies, e.g. ILO (for rehabilitation of the disabled) and WFP (especially for supplementary feeding) will also be necessary. For this purpose, the establishment of a Health Coordinating Committee with representation from all relevant UN agencies as well as from NGOs is proposed to ensure well-coordinated implementation.

the return of refugees and internally displaced persons starts.

Training syllabi for various categories including retraining of the already trained and refresher training will be structured. Priority will be given to training/retraining of primary care health workers including community health workers and TBAs, aimed at imparting basic skills in preventive, promotive and emergency curative care including basic delivery practices, sanitation and nutrition education and case detection techniques for major health problems.

Training programmes will be initiated in existing refugee areas as well as across the border in cooperation with selected NGOs having potential for and experience in training of health personnel.

Training of supervisors and managers will be an important part of the overall training programme.

The training institutes in the country will be strengthened quantitatively and qualitatively. Maintainance and repair of training institutes will need attention and deficiencies in educational equipment, material and supplies will be made up.

The training and staffing needs and development of health manpower will be an essential term of reference for the proposed "Needs and Services Assessment Mission" whose findings will facilitate detailed planning and implementation. The Management Component, described later, makes provision for preparation of training programmes, conduct and supervision of training.

A total sum of US$ 7.50 million (US$ 2.50 million for the immediate relief phase and US$ 5.0 million for the recovery and rehabilitation phase) has been estimated to cover the costs of training of health personnel.

III. C. Survey, Planning and Management

Surveys

In order to assess needs and programmes/services available, it will be essential to undertake survey/planning missions in the refugee areas as well as in Afghanistan, so that relevant and latest information is fed into the planning process. One such mission to be organised, as soon as possible, is proposed in order to assess existing health services and determine needs. The mission will be composed of an epidemiologist, health planner and one or two other members drawn from technical divisions connected with areas of major concern (e.g. drugs and supplies, health manpower development, etc.).

An immediate rapid survey bringing out salient information is proposed. The questionnaire outlining significant information necessary for immediate planning and forecasting estimates is attached. Information will be collected by the survey mission itself as well as with the assistance of NGOs operating in the health and health-related fields particularly in areas which cannot be visited by the mission.

Planning

Initial planning is already underway. Programme outlines and estimated costs were prepared and included in the appeal to the donor community by the UN Secretary General and the the UN Coordinator for Afghan Recovery and Rehabilitation. More detailed planning has also been done and is included in the present document. All this, of necessity, had to be done in the light of scant - and in some cases, unreliable - information. Plans so far submitted, therefore, have to be flexible so as to incorporate any amendments that may be necessary in the light of more concrete information that may become available.

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The management components and costs are given below:

	Costs US$
1. Personnel (Calculated at \$ 8 000/professional/month; \$ 2 500/sec. support/month; \$ 1 500/custodial staff/month).	
For Kabul/Peshawar	
4 Professional Field Staff (1-Team Leader, 1-Technical Officer, 1-Epidemiologist, 1-HMD/Training Officer)	576 000
1 Administrative Assistant	
2 Secretaries	135 000
4 Drivers	108 000
2 Custodial Staff	54 000
For HQ/Geneva	
1 Professional (Planning/Coordination/Evaluation and also coordination with EMRO)	144 000
1 Secretary	45 000
Travel and per diem	
at \$ 30 000/professional	225 000
Sub-total	1 287 000
Consultants	
30 m/m for 10 missions (p.d. & salary \$ 8 000/consultant/month) (Travel costs \$ 2 500 /consultancy mission)	
Per diem & salary	240 000
Travel	25 000
Sub-total	265 000

Field Supervisors		
Required for implementation/supervision of specific programmes (e.g. malaria control, TB control, CDD, training) and coordination with NGOs/other agencies for work in the field. (calculated at $ 2 500/supervisor/month)		
12 Supervisors - salaries		540 000
12 Drivers - salaries		324 000
Per diem for travel		73 440
	Sub-total	937 440
2. Equipment & Operating Costs		
Office equipment		
($ 25 000/professional)		150 000
($ 8 000/supervisor)		96 000
Field/Office operating costs		
$ 4 000 per professional		36 000
$ 2 000 per supervisor		36 000
Paper printing for Health Information System		50 000
Misc. operating costs		50 000
	Sub-total	418 000
3 Vehicles		
(for field operational duties (one for each professional and supervisor)		256 000
(Average cost $ 16 000)		
Operational costs		216 000
	Sub-total	472 000
4 Emergency management-related		
Training (1 month training for 100 individuals est. $ 1 000 person/month)		100 000
	Sub-total	100 000
	Total	3 479 440
+ 15% contingency		555 666
+ 13% PSC		553 814
	Grand total	4 588 920

Costs of missions/consultancies shown above relate to initial and urgent requirements. The management component and technical support as well as additional evaluation and planning missions/consultancies will be required for long-term support to the national health services. The balance of US$ 7.50 (after meeting the above costs) shown in total costs against this budget-line has been provided for this purpose.

WORLD HEALTH ORGANIZATION ORGANISATION MONDIALE DE LA SANTE

Emergency Relief and Rehabilitation for Afghanistan

WHO OPERATIONAL DOCUMENT WITHIN
THE SECRETARY GENERAL'S APPEAL

1 September 1988

Emergency Preparedness and Response
WHO Geneva

WORLD HEALTH ORGANIZATION

ORGANISATION MONDIALE DE LA SANTÉ

TABLE OF CONTENTS

Health Sector Programme of the
UN Humanitarian and Economic Assistance to Aghanistan